

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH  
OFFICE OF THE CHIEF DEPUTY DIRECTOR

HOUSING ASSISTANCE PROGRAM

CERTIFICATION OF RESIDENCE IN A HOMELESS FACILITY

I, \_\_\_\_\_ hereby  
authorize \_\_\_\_\_  
to release information related to my homeless status to the Department of Mental Health.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Date

**CERTIFICATION**

I certify that \_\_\_\_\_ stayed at \_\_\_\_\_  
(Name of applicant) (Name of facility)  
from \_\_\_\_\_ to \_\_\_\_\_.

Before coming to this facility, the applicant reported residing at: (Include a street address if applicable)

\_\_\_\_\_  
\_\_\_\_\_

from \_\_\_\_\_ to \_\_\_\_\_.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Signature of facility staff person)

**Title:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Facility:** \_\_\_\_\_  
(Name and address of facility)

**Type of Facility:**

- ☐ Emergency Shelter
- ☐ Transitional Housing
- ☐ Institution
- ☐ Residential Care Facility
- ☐ Other - Specify \_\_\_\_\_